MDR Tracking Number: M5-04-2565-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 4-16-04. "V".

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that functional capacity evaluations and a work hardening program from 9-11-03 through 10-28-03 were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 19, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT codes 97545 and 97546 on 10-27-03: Review of the requester's and respondent's documentation revealed that the only EOB submitted contained a denial code of O which states that it is a "denial after reconsideration". This is proof of submission. Therefore, the disputed service or services will be reviewed according to the fee guidelines for a CARF accredited facility. Recommend reimbursement of $128 for the initial hour and $256 for the five additional hours for a total of $384.

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 10-27-03 in this dispute.

This Order is hereby issued this 30th day of September 2004.

Donna Auby

Medical Dispute Resolution Officer

Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

July 14, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-2565-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ___ when she was lifting/emptying dishes and felt pulling and burning in her lower back. An examination by a chiropractor revealed that the patient was experiencing constant/aching low back pain that increased with movement, twisting, and bending. Treatment for the patient's condition included a work-hardening program.

Requested Service(s)

Functional capacity evaluations and work hardening program from 09/11/03 through 10/28/03.

Decision

It is determined that the functional capacity evaluations and work hardening program from 09/11/03 through 10/28/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

While there are voluminous medical records indicating that the work hardening program was performed, there is no medical record documentation to substantiate the medical necessity for the treatment or the functional capacity evaluations. The treatment records indicate that the treatment was not beneficial. Specifically, the patient's pain rating was 6 at the initiation of work hardening and 7 at the termination of treatment. In addition, the work hardening program failed to achieve any of the goals that were established for the treatment.

Sincerely,